



Disease Alert Report

Name of Submitter:

Patient's Unit:

Date:

PATIENT INFORMATION:

Last Name:

First Name:

Middle Initial:

Social Security Number:

Rank/Grade:

Branch of Service: Coast Guard

Date of Birth:

Gender: Male Female

Race: White Black / African American American Indian / Alaskan Native

Asian Hispanic Pacific Islander Other

MEDICAL INFORMATION:

Clinical Diagnosis (ICD-9 Code):

Clinical History:

Laboratory Results:

Treatment:

Additional Information (e.g. Outbreak):

Health Department Notification: Yes No

Community Threat: Yes No

Point of Contact:

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Please complete this form within 7 days and email to HQS-DG-Disease Alert Report.